

"Big Boys Don't Cry!" Or Do They? : Can Forensic Patients Change?

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***“Big Boys Don’t Cry!” Or Do They?
Can Forensic Patients Change?***

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Crying psychopaths? What a crazy idea! Think about your “favorite” psychopath: Jeffrey Dahmer, or Hannibal Lecter, for example. Everyone knows that psychopaths have no feelings. Psychopaths have no conscience. They lack empathy for other people. They callously use and manipulate them. Crying psychopaths? Forget about it! Yet, our images of psychopaths, which are formed from the heinous crimes that they commit, and from the media, where they are sensationalized, may cause us to miss some important observations. In fact, sometimes, psychopaths *do* cry. Let me give you some examples.

- A former enforcer in a criminal network contracted AIDS. When speaking of the people he’d hurt or killed, he suddenly broke into tears, and expressed remorse.
- A psychopathic patient told his therapist not to bother looking for emotions, because he was a psychopath. However, when he was suddenly hospitalized, and his girlfriend came to visit, he began to cry.
- A psychopathic patient hit a staff member and was placed in separation. When his therapist visited him and expressed sympathy, he cried.

And I could give you many other, similar examples, especially of patients who are in our Schema Therapy research project, which I’ll describe momentarily. How do we make sense of these observations? They seem to fly in the face of the established wisdom about psychopaths. None of these patients seemed to be “faking it.” There was no apparent ulterior motive for feigning emotion here. These emotional displays seemed to be spontaneous and genuine. In all of these cases, the patients seemed to flip or switch into a vulnerable emotional state, a state quite unlike the callous, detached state that they normally experienced. The circumstances involved – being diagnosed with AIDS, being suddenly hospitalized, being placed in separation – seemed to have pierced the armor of these patients, enabling them to experience feelings that were normally inaccessible to them. Apparently, some of these individuals are capable of experiencing vulnerable emotions under certain circumstances, circumstances that trigger vulnerability. Or to put it another way, psychopaths aren’t the same way all of the time. In this sense, they are like the rest of us.

Let's take a closer look at psychopathy. Psychopathy is usually defined by the presence of certain personality traits as well as certain behavioral features. The personality traits, which are usually considered the core features of the disorders, are divided into emotional features, such as lacking emotions, lacking empathy for others, or remorse for one's crimes, and interpersonal features, such as manipulating others, being grandiose and dominant, and exploiting others in a ruthless, predatory manner (Hare, 1991). Psychopathy is usually assessed by the Psychopathy Checklist-Revised (PCL-R; Hare, 1991), an interview that measures the affective and interpersonal features of psychopathy, as well as an unstable, impulsive antisocial "lifestyle" and antisocial behavior. Considerable research has shown that psychopaths – usually defined by a PCL-R score of 30 or higher – are at considerably greater risk for committing future crimes and acts of violence ("recidivism"), compared to other criminals. Within one to three years after being released from forensic institutions, their risk of recidivism is two to four times higher than that of other patients (Hemphill, Hare, & Wong, 1998; Salekin, Rogers, & Sewell, 1996). Thus, psychopaths represent a group that poses a considerable danger to society.

Psychopathy: Pessimistic views. For the past 200 years, psychopathy has been largely considered to be an inherited brain disorder, and therefore an unchangeable condition. Indeed, there is some research supporting the notion that psychopaths have neuropsychological and biological deficits (Blair, 2005). Psychopaths have difficulties recognizing fear in the faces or voices of other people (Blair, 2005). Moreover, when viewing fearful faces, the amygdala, the brain area responsible for recognizing fear, fails to "light up" (Marsh & Blair, 2008). Similar deficits seem to be present in some children, who appear to lack empathy; children with so-called "callous-unemotional traits." Twin studies show that callous-unemotional traits in children have a considerable genetic component (Taylor, Loney, Bobadilla, Iacono, & McGue, 2004; Viding, Blair, Moffitt, & Plomin, 2005). Given this evidence of neuropsychological and biological evidence deficits in psychopaths, is it any wonder that many experts believe that psychopaths can't change?

In fact, many experts, as well as treatment professionals working with forensic patients, believe that psychopaths cannot be treated (Harris & Rice, 2006). Furthermore, many believe that psychotherapy makes psychopaths worse, by teaching them the psychological skills to better manipulate others; in effect,

psychotherapy teaches them to become better psychopaths (Harris & Rice, 2006; Rice, Harris, & Cormier, 1992). Even those who profess to be more optimistic about the possibilities of treating psychopaths view them as essentially handicapped. For example, the “no cure but control” model (Laws, Hudson, & Ward, 2000) suggests that while psychopaths can’t be cured, they may learn to control their aggressive behavior, if they are sufficiently motivated to do so. Yet, this approach is dependent on the motivation of the patient, which varies, and may diminish once he leaves the forensic institution.

Surprisingly, however, there is little or no evidence from randomized clinical trials supporting the view that psychopaths can’t be treated (D’Silva, Duggan, & McCarthy, 2004; Salekin, 2002). In fact, not a single methodologically sound randomized clinical trial has been conducted to investigate this question. All of the previous studies on this topic have been marred by serious methodological flaws, such as a lack of random assigned to experimental and control treatments, a lack of appropriate treatments, or inadequate measures of treatment outcomes (D’Silva et al., 2004). Our own randomized clinical trial of Schema Therapy (Bernstein & Nijman, submitted), which I’ll describe in a moment, was designed to overcome these deficiencies. Thus, the fact of the matter is, we simply don’t know whether psychopaths can be treated; up until now, there has been no solid empirical evidence on which to base these judgments.

Some recent studies are more optimistic with respect to the possibility of treating psychopaths (Chakhssi, de Ruiter, & Bernstein, 2010; Skeem, Monahan, & Mulvey, 2002). For example, a study in a Dutch forensic hospital (Chakhssi, de Ruiter, & Bernstein, 2010) examined change among forensic inpatients with personality disorders, using a nurse-rated instrument, the BEST-index (Reed, Woods, & Robinson, 2000). Patients were classified according to “reliable change” (Jacobson & Truax, 1991), that is, whether they showed improvement that was greater than what would be expected by chance fluctuations, due to measurement error. Only a small percentage of psychopathic and non-psychopathic patients – about 7% - showed overall deterioration over the 20-month interval during which they were tested. A substantial proportion, 59%, of the non-psychopathic patients improved. However, a considerable minority of the psychopathic patients, 37%, also improved – a non-significant difference from the psychopathic group - belying the notion that psychopaths can’t change. In addition, 20% of the psychopaths showed a

worsening in aggression, compared to none of the non-psychopaths. These findings suggest that some psychopaths can indeed benefit from forensic treatment, although there also appears to be considerable room for improvement. And a significant minority of psychopaths got worse, rather than better, in terms of aggression. Of course, these findings don't tell us anything about what happens when psychopaths are released from the hospital. While psychopaths remain a very challenging group to treat, the categorical view that they cannot be treated at all, or that treatment makes them worse, doesn't appear to hold up to scrutiny.

An alternative view: From trait to state. The central insight that informs our approach to treating psychopaths is that, like other people, these patients aren't the same way all of the time. Until now, psychopaths have been described in terms of traits, that is, long-term, enduring features of their personalities, such as lack of empathy, manipulateness, and so forth (Hare, 1991). Yet, trait theories make the assumption that people are the same way all the time. They describe personality in terms of what we can expect on average across different situations. But as we have seen, psychopaths may show very different sides of themselves under the right circumstances. Thus, in addition to trait models of psychopathy, we need a new model based on emotional states, which describes moment-to-moment fluctuations in thoughts, feelings, and behavior. Our goal is to break through the emotional detachment of psychopaths to reach more vulnerable emotions. If we can flip or switch psychopaths into more vulnerable states, we may be able to help them to develop greater capacity for feeling, including developing so-called "moral emotions," such as empathy, guilt, and shame.

Schema Therapy. The approach that we use to achieve this breakthrough to emotion is known as "Schema Therapy" (Rafaeli, Bernstein, & Young, 2011; Young, Klosko, & Weishaar, 2003). Schema Therapy was developed about 20 years ago by Dr. Jeffrey Young. It is an integrative form of psychotherapy that combines cognitive, behavioral, psychodynamic object relations, and humanistic/experiential approaches. Schema Therapy was created specifically as a treatment for personality disorders. Many patients with personality disorders respond poorly to standard forms of cognitive-behavior therapy. These patients appear to need more than what standard cognitive-behavior therapy can offer. First, they need a treatment that focuses especially on the attachment relationship with the therapist, given their own frequent histories of insecure attachment with caregivers (Crawford et al., 2007). Second,

they need more emphasis on processing emotions, given their emotional difficulties, such as emotional detachment or emotional instability (Holmes & Mathews, 2005). Third, they need an emphasis on dealing with the past, and not only on the present, given their frequent histories of traumatic experiences, such as child abuse and neglect (Johnson, Cohen, Brown, Smailes, & Bernstein, 1999). Schema Therapy provides all of this: a focus on the attachment relationship with the therapist, known as “limited reparenting;” emotion focused techniques, borrowed from Gestalt Therapy, such as role playing (Kellogg, 2004; van den Broek, Keulen-de Vos, & Bernstein, 2011) and imagery rescripting (Arntz, 2011; Holmes & Mathews, 2005), to evoke and reprocess emotions, including those stemming from traumatic experiences; as well as cognitive techniques to restructure cognitions, and behavioral techniques to teach more effective coping skills.

Schema Therapy is a moderate- to long-term form of treatment that aims for genuine personality change. For patients with severe personality disorders, therapy often lasts two to three years or even longer. The effectiveness of Schema Therapy for Borderline Personality Disorder – considered one of the most challenging personality disorders to treat – has been confirmed in three separate studies, including two randomized clinical trials (Farrell, Shaw, & Webber, 2009; Giesen-Bloo, et al., 2006) and one implementation study (Nadort, et al., 2009). In the first of these studies (Giesen-Bloo et al., 2006), 50% of patients receiving Schema Therapy were judged to be recovered from their Borderline Personality Disorder symptoms, and 70% showed clinically significant improvement, after three years of treatment and a one-year follow-up. Schema Therapy was about twice as effective as a psychodynamic treatment to which it was compared, Transference Focused Psychotherapy. Schema Therapy patients showed improvements in nearly all of the areas that were assessed – identity disturbance, impulsivity, intense relationship, and so forth – and not just in self-harm symptoms of Borderline Personality Disorder, such as suicide attempts and self-mutilation. Schema Therapy also succeeded in retaining a much higher proportion of patients in treatment: only 27% of Schema Therapy patients dropped out within three years, compared to 50% of patients receiving the control treatment. Schema Therapy also proved to be highly cost-effective (van Asselt, et al., 2008), and was associated with improvements in patients’ quality of life (Giesen-Bloo et al., 2006). It was these impressive results that led my colleagues and I (Bernstein, Arntz, & de Vos, 2007) to adapt Schema Therapy for

forensic patients with personality disorders, including psychopathic patients, who are often considered difficult or impossible to treat.

Schema modes. In Schema Therapy, “schema modes” are the key to working with severe personality disorders (Rafaeli et al., 2011; Young et al., 2003). Schema modes are fluctuating emotional states that temporarily dominate a person’s thoughts, feelings, and behavior. Patients with personality disorders have poorly integrated personalities. As a result, they can fluctuate rapidly from one extreme emotional state to another, or remain stuck in a particular emotional state. The classic example is Borderline Personality Disorder. Patients with Borderline Personality can, in the same therapy session, fluctuate suddenly between states of extreme emotional vulnerability, where they feel intensely painful emotions, to states of rage, to states of dissociation, where they become extremely emotionally detached, “numb.” Schema modes can present real challenges for the therapists who treat these patients. It’s a little like trying to “hit a moving target.”

In Schema Therapy, we teach therapists to recognize and work with patients’ fluctuating schema modes. Thus, therapists learn to monitor the fluctuations in patients’ modes as they occur, and to adjust their technique accordingly. Different emotional states call for different types of interventions. For example, when a patient is feeling and expressing vulnerable emotions, the therapeutic approach is much different than when a patient is angry or emotionally detached. The therapist works with the state that the patient is in at a particular moment in time. In general, the goal is to flip or switch the patient from unproductive states – such as emotional detachment – to more productive ones, such as states of emotional vulnerability and healthy self-reflection. We also teach patients how to recognize and deal with their own emotional states. We teach them the schema mode “language,” using terms that are easy to understand, and are morally and emotionally neutral, such as the “Vulnerable Child side,” the “Angry Child side,” and the “Detached side.” When the patient and therapist use the same language to describe the patient’s emotional states, it allows them to address problematic situations, such as interpersonal conflicts, in more productive ways. For example, the therapist can ask the patient, “I just noticed this shift, where all of a sudden you seemed to become emotional distant, as if you lost touch with your feelings. What side of you is this?” The schema mode concept is essentially an accepting, rather than judgmental, one. It assumes that all human beings have different sides of themselves – different emotional states.

Even though some of these states, such as aggressive ones, have severe consequences, they exist for a reason, for example, to protect the person from a perceived threat. This non-judgmental and accepting attitude enables the patient to speak freely and openly about the different sides of him, a major advantage in dealing with patients with severe personality disorders, such as those in forensic settings.

In order to adapt Schema Therapy for forensic patients, we needed to describe the schema modes that are typically seen in forensic populations. We identified a cluster of five modes that appear most characteristic of patients who are antisocial and psychopathic (Bernstein et al., 2007; Bernstein, Keulen-de Vos, Jonkers, de Jonge, & Arntz, 2012; Keulen-de Vos, Bernstein, & Arntz, in press). All of these modes, known as “over-compensator modes,” are characterized by “turning the tables” on the other person, or “taking the upper hand.” The Self-Aggrandizer mode is a state of dominance, superiority, or arrogance, where the patient places himself above other people, who are devalued or denigrated. The Bully and Attack mode involves the use of threats, intimidation, or aggression to get something that the patient wants, or to protect him from perceived threats. In the Paranoid Over-controller mode, the patient focuses his attention like a laser-beam to find the person who is against him. In the Conning Manipulator mode, the patient “play acts” a part to get something he wants in a covert, devious way. The Predator mode is a state of cold, ruthless aggression, in which the patient “eliminates” an obstacle, threat, or rival that is standing in his way. Our working hypothesis is that behind these extreme schema modes, as well as modes involving emotional detachment, lie more vulnerable, child-like sides of the patient. These sides usually remain hidden, but can become revealed unexpectedly under certain conditions. The goal of Schema Therapy is to ameliorate these over-compensator and detached modes; heal the early emotional wounds that lie in the patient’s vulnerable side; help the patient to develop greater frustration tolerance and the ability to control his impulsive side; learn to express his anger in more balanced and productive ways; and increase his capacity for healthy self-reflection and for spontaneous joy and playfulness. Thus, Schema Therapy aims for genuine personality change by modifying patients’ schema modes.

Schema modes and crime. Our theory is that schema modes play an important role in patients’ criminal and violent behavior. In fact, we view modes as

the psychological risk factors for antisocial behavior. If we can modify patients' modes, we can lower their risk of crime and violence. But is there any empirical basis for this theory? In one recent study, my colleague, Marije Keulen-de Vos, investigated the relationship between schema modes and crime in 95 forensic patients with personality disorders (Keulen-de Vos, et al., manuscript in preparation). She used an assessment tool that we developed, the Mode Observation Scale (MOS; Bernstein, de Vos, & van den Broek, 2009), which she modified to assess modes retrospectively from the descriptions of the crimes found in their dossiers. Raters who were trained to use the MOS were able to assess modes reliably in this manner. The study compared schema modes in two situations – the events leading up to the crime, and during the crime itself. The findings of this study support our theory that vulnerable emotions play a role in triggering many crimes, while over-compensator modes are active during crimes themselves. In the period leading up to the crimes, patients showed significantly more vulnerability and loneliness than during the crimes; in contrast, during the crime itself, they showed significantly more anger and impulsivity, bullying, and predatory behavior, than before the crime. Interestingly, psychopathic patients with more affective features of psychopathy – such as lacking empathy and remorse, and being emotionally unresponsive – showed significantly less vulnerability in the period leading up to their crimes. This suggests that either they are less likely to show emotions overtly, in ways that others can observe them, or that their motives for committing crimes are different, perhaps having more to do with needs for power or rewards, rather than compensating for feelings of vulnerability. Thus, this study supports the idea the schema modes play an important role in crime and violence, an important underpinning for our treatment approach, which attempts to lower risk by modifying modes. It also underscores the importance of recognizing heterogeneity in treating antisocial and psychopathic patients. These patients may vary in terms of the motives that drive their criminal behavior. The schema mode approach enables us to tailor the therapy to the modes that represent risk factors for specific individuals.

Treatment approach for offenders. “Limited reparenting” is the central feature of our treatment approach with antisocial and psychopathic patients (Rafaeli et al., 2011; Young et al., 2003). In limited reparenting, the therapist adjusts his style to provide some of what the patient missed growing up, within reasonable limits and boundaries. Put another way, the therapist focuses on the patient's unmet, early

developmental needs, such as the needs for attachment, validation and expression of emotions, autonomy, spontaneity and play, and firm but fair limits and boundaries. In our experience, antisocial and psychopathic patients require much more time to form an attachment with the therapist than is the case for other patients. The therapist must remain patient and persistent, and continue to focus on the patient's wall of emotional detachment, with the goal of making contact with genuine emotions. The therapist is assisted in this task by the use of the schema mode model, which enables him to call attention to, and discuss, the patient's emotional reserve, as well as other schema modes that block therapeutic progress (e.g., a self-aggrandizing side, where the patient tries to put himself above the therapist, or a bullying side, which tries to back the therapist into a corner). The therapist also uses other techniques, such as empathically confronting the patient about his problematic emotional states, and setting limits on problematic modes, when these modes threaten to undermine the treatment. In addition, the therapist uses emotion-focused techniques, such as role playing and imagery rescripting (Rafaeli et al., 2011; Young et al., 2003), to bypass patients' maladaptive modes, and reach more vulnerable states, where the therapist can begin to heal the patient's underlying early maladaptive schemas – the early emotional “wounds” that develop when children's basic developmental needs are not met (Rafaeli et al., 2011; Young et al., 2003).

Antisocial and psychopathic patients have tremendous levels of mistrust (Chakhssi, Bernstein, & de Ruiter, submitted), and also need consistent empathic confrontation and limit setting on the sides that try to turn the tables on other people. Forming an attachment relationship with these patients, and making a breakthrough to real emotions, isn't easy. However, in our experience, after one year to one and a half years of therapy, fundamental changes begin to take place. The patient is experienced by other people as becoming a little “softer.” His “hard edges” aren't so pronounced. He has less conflictual relationships with other people, and begins to develop feelings of trust, first towards his therapist, and then towards other people, such as ward staff. Thus, we see changes in his schema modes taking place – less over-compensator and detached emotional states, and more genuine emotion and connection. We need to be realistic in our expectations. Some level of risk is likely to remain in these patients. However, even these gradual changes in patients' modes are usually accompanied by a lessening in problematic behaviors and incidents in the hospital, as well as lowered scores on standardized risk assessment

instruments. These lowered levels of risks often lead to approval of patients' application to go on leave, a major step towards re-entering the community.

How many psychopathic patients can benefit from Schema Therapy? We don't yet know. The literature on psychopathy suggests that it is a heterogeneous condition (Murphy & Vess, 2003; Vassileva, Kosson, Abramowitz, & Conrod, 2005), with patients varying in their capacity to form attachments and experience vulnerable emotions. In our experience, many, or perhaps most, psychopathic patients have sufficient capabilities to engage in this form of treatment. On the other hand, patients who are completely incapable of experiencing emotions or forming attachments wouldn't be expected to profit from Schema Therapy. Ultimately, the question of how many patients can benefit from Schema Therapy is empirical in nature. The results of our research so far (see below), and the growing literature on the heterogeneity among psychopathic patients, suggest that many of them can potentially benefit from this approach.

Randomized clinical trial. Since 2007, we have been studying the effectiveness of our forensic adaptation of Schema Therapy in a major randomized clinical trial that is taking place in the Netherlands (Bernstein & Nijman, submitted). The study is supported by the participating TBS clinics, the Netherlands Ministry of Safety and Justice, the Expertise Center for Forensic Psychiatry, and Maastricht University's Faculty of Psychology and Neuroscience. One hundred three patients from seven forensic psychiatric hospitals ("TBS clinics") are participating in the project: Forensic Psychiatric Centers de Rooyse Wissel, van der Hoeven, Oostvaarders, Mesdag, Veldzicht, and Kijvelanden, and Forensic Psychiatric Clinic Assen.

This study is the first clinical trial in which the majority of TBS clinics, seven out of 12, are participating, and thus represents a milestone in the collaboration among these institutions. It grew out of recommendations by the Dutch parliament that TBS clinics should collaborate with each other and with universities to conduct research directed at the improvement of forensic treatment (Tweede Kamer der Staten Generaal, 2005/2006). The study is also unique worldwide: the first large scale randomized clinical trial of forensic patients with personality disorders, including a substantial number of psychopaths, ever to be conducted.

The study is a three-year clinical trial with a three-year post-treatment follow up. Patients at each clinic are randomly assigned to receive either Schema Therapy

or usual forensic treatment (“treatment-as-usual”). Patients in the study have DSM-IV diagnoses of Antisocial, Borderline, Narcissistic, or Paranoid Personality Disorder. Antisocial Personality Disorder is characterized by criminal behavior, and a reckless, impulsive, irresponsible lifestyle. About 80% of incarcerated offenders have an Antisocial Personality Disorder. About 20% to 30% of these patients are considered to be psychopaths: the most severe subgroup of antisocial offenders. Borderline Personality Disorders is characterized by intense, unstable emotions and relationships, and an unstable sense of identity. Narcissistic Personality Disorder is characterized by an egocentric disregard of others’ needs, rights, or feelings. Paranoid Personality Disorder is distinguished by an extreme mistrust of other people. Only male patients were included, as the vast majority of TBS patients are male. There were several exclusion criteria, such as schizophrenia, bipolar disorder, autistic spectrum disorders, and low intelligence (IQ less than 80). The vast majority of the patients, about 90%, committed violent offenses, including sexual offenses and non-sexual offenses.

The primary aims of the study are to compare the effectiveness of Schema Therapy versus treatment as usual with respect to several treatment outcomes: reduction in personality disorders symptoms; aggression and other incidents during the forensic hospital stay; approval to go on leave, a crucial step in the patient’s process of “resocialization” into the community; reduction of recidivism risk – i.e., the patient’s risk of re-offending – as assessed by standardized risk assessment instruments; and actual recidivism, that is, arrests and convictions, after the patient has returned to the community.

Preliminary findings. The first cohort of 30 patients who began the study in 2007 have already completed the three-year treatment phase of the study, giving us a “sneak preview” of how the final results might look in our complete sample (Bernstein & Nijman, submitted). Sixteen of the 30 patients were randomly assigned to receive Schema Therapy; 14 of them received treatment as usual. More than 85% of the patients in the sample had a DSM-IV diagnosis of Antisocial Personality Disorder, with 30-40% having a Borderline or Narcissistic Personality Disorder (percentages don’t add up to 100%, because patients may receive more than one diagnosis). Although there were no statistically significant differences between the treatment groups in this small sample (i.e., the sample is still too small to conclude

that the findings couldn't be attributed to chance), the trends that emerged are quite interesting.

In interpreting the preliminary results, one should note that the patients in the Schema Therapy condition started treatment at a disadvantage compared to the patients receiving treatment as usual. Just by chance, a much higher percentage of the Schema Therapy patients, 37.5%, were highly psychopathic, having a PCL-R score of 30 or higher, compared to only 14.2% of the treatment as usual patients. Because they had higher levels of psychopathy, they started treatment with high levels of recidivism risk, compared to medium levels of risk in the treatment as usual patients. These differences between the two treatment conditions will no doubt equalize in the complete sample, because such differences even out in larger samples, when random assignment is used. However, when interpreting these preliminary results, this means that the Schema Therapy patients were more impaired than the treatment as usual patients at the start of treatment.

In our study, the patients' risk levels are assessed every six months for the three-year duration of treatment, using the Historical, Clinical and Risk management scheme (HCR-20; Douglas & Webster, 1999). When comparing the more psychopathic patients who received Schema Therapy versus treatment as usual, a clear trend is evident: those in the Schema Therapy condition showed a rapid decline in their risk levels from high to medium risk over the first 18 months of treatment; in contrast, the more psychopathic patients who received treatment as usual showed no change in their risk levels in the first year of treatment, and only a modest decline from 12 to 18 months. By 18 months, the Schema Therapy patients' risk levels had caught up to those of the treatment as usual patients (Bernstein & Nijman, submitted). The risk levels of both groups continued to decline thereafter, reaching medium to low levels by the end of three years. Thus, Schema Therapy appeared to promote more rapid improvements in the patients who had higher levels of psychopathy, a noteworthy finding, given the supposed untreatability of these patients. Patients with lower psychopathy scores who received Schema Therapy also improved more quickly than in the treatment as usual condition, though the differences appeared to be smaller than for the more highly psychopathic patients. This confirms the impression, supported by research, that treatment in TBS clinics works for many patients (Bernstein & Nijman, submitted). However, the greatest

benefits of Schema Therapy, compared to usual treatment, appear to be in the patients with higher levels of psychopathy.

These findings are mirrored in the data on the patients' progress into, and through, the resocialization phase of treatment. Resocialization is a key aspect of treatment in Dutch forensic hospitals. If a patient's risk level is deemed to be sufficiently low, he is granted permission to begin a gradual process of reintroduction into the community, starting with short periods of supervised leave, and eventually, if the leave process continues to go well, longer periods of unsupervised leave. All decisions regarding permission for leave are based on a stringent process of evaluation, including assessment using standardized risk assessment measures, approval by a "leave board" within the forensic institution, and independent evaluation by a psychologist and psychiatrist, with final approval given by the Ministry of Justice. The consequences of receiving, or not receiving, permission for leave are great. Patients whose risk levels remain high even after lengthy treatment, and are unable to obtain leave, are eventually sent to special "long-stay" units, where they reside for an indefinite period. Thus, the resocialization process is essential to the success of treatment in the Dutch forensic system. It means the difference between re-integration into the community and potentially life-long detention.

Our preliminary data show that a higher proportion of patients given Schema Therapy receive permission to go on leave, both supervised and unsupervised leave, than the patients given treatment as usual. After two years of treatment, about twice as many patients in the Schema Therapy condition had received leave than in the treatment as usual condition (Bernstein & Nijman, submitted). Moreover, the Schema Therapy patients received leave an average of four to six months more quickly than those receiving usual treatment. This difference is particularly noteworthy, given that the Schema Therapy patients were more psychopathic at baseline assessment, and therefore started treatment with higher levels of risk. Thus, our preliminary findings suggest that Schema Therapy facilitates patients' reintegration into the community, including for more psychopathic patients. In recent years, the average length of stay in TBS clinics has risen from six years to nearly 10 years, partly due to the implementation of risk assessment procedures, which have allowed patients' risk levels to be determined with greater accuracy (Bernstein & Nijman, submitted). On the other hand, developments in forensic treatment have not kept pace with these

advances in assessing risk. If Schema Therapy can reduce patients' risk levels, thereby reducing their length of stay, it would help to redress this imbalance.

If Schema Therapy proves to reduce patients' length of stay in forensic institutions, it would also prove to be highly cost-effective. We have estimated the cost of three years of Schema Therapy, including training and supervision costs, and the salary of an experienced therapist, to be €20,392 (Bernstein & Nijman, submitted). This is the cost of Schema Therapy, over and above that of treatment as usual. However, treatment in TBS clinics is also expensive: an average of about €160,000 per year for each patient. Thus, the entire cost of three years of Schema Therapy can be fully recouped by reducing the patient's length of stay in the clinic by just two months. And this cost savings doesn't even include the tremendous savings that would occur if Schema Therapy proves to reduce recidivism. Criminal behavior is tremendously costly for society, including the costs of apprehending, prosecuting, and detaining criminals, as well as the costs of damage to people and property. And of course, the human toll of crime and aggression is staggering. If we can reduce patients' risk of recidivism, especially in psychopathic patients whose recidivism risk is two to four times higher than in other criminal offenders (Salekin et al., 1996), it can help to reduce this financial and societal burden.

Finally, what about our contention that Schema Therapy can reach the more vulnerable side of forensic patients? Our preliminary data support this contention. In a pilot study (van den Broek et al., 2011), we rated videotapes from 40 therapy sessions to assess emotional states (i.e., schema modes) in 10 randomly selected patients from our randomized clinical trial, six who received Schema Therapy, and four who received treatment as usual. The ratings were made from therapy sessions that took place at about 12 to 18 months into treatment – long enough to see the effects of Schema Therapy, if they were there to be seen. Patients who received Schema Therapy showed twice as much emotional vulnerability as patients who received treatment as usual, a difference that approached statistical significance ($p=.09$). Thus, Schema Therapy appears to be more effective than usual forensic treatment at evoking vulnerable emotions, a central tenet of our approach.

I should emphasize once again that these findings are preliminary. The sample of patients who have completed the study is still too small to draw any definite conclusions from them. We need to await the results in our entire sample, which will complete the treatment phase of the study in 2015, as well as the results of

our follow-up study, which will be finished in 2018, before we can draw more definite conclusions about the effectiveness of Schema Therapy with this challenging population. Nevertheless, these results suggest that Schema Therapy is a promising form of treatment for forensic patients with personality disorders.

Conclusions. In closing, can forensic patients change? Our tentative conclusion is that many of them can, including some psychopathic patients, a group that is often considered difficult or impossible to treat. Treating these patients requires a radical reconceptualization of their personality disorder pathology, from a trait view to a state view, as well as a treatment approach that focuses on their problematic emotional states and attempts to reach a more vulnerable side of them. Of course, many questions remain about the possibilities of change in these patients. How many of them can change? Which patients can change, and which can't? In what ways do these patients change, and to what degree? And most important, can their risk of recidivism be reduced over the long run? The answers to these questions are of profound scientific, as well as societal, importance. Our randomized clinical trial will be able to provide answers to many of these questions. The insights that we will gain is a testament to the efforts being made by the TBS clinics, the organizations that are supporting them, and the many therapists, staff, and patients who are participating in this project.

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